**Department of Behavioral Health**

# TRANSMITTAL LETTER

| SUBJECT<br>Level of Care Determination for Adults in MHRS | | |
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| POLICY NUMBER<br>DBH Policy 300.1 | DATE OCT 0 1 2014 | TL# 268 |

**Purpose**. To establish policy and procedures in utilizing the Department of Behavioral Health's (DBH) approved tool for level of care (LOC) determination for all adult consumers enrolled in a core services agency (CSA). This version has removed the Child and Adolescent Level of Care Utilization System (CALOCUS) component and refers to the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) for functional assessment.

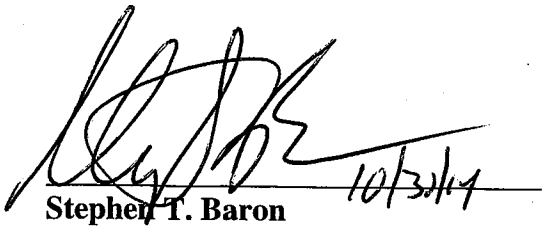
**Applicability.** DBH certified core services agencies (CSAs), sub-providers, and specialty providers and the Behavioral Health Authority (BHA) serving active adult consumers in Mental Health Rehabilitation Services (MHRS), and MHRS consumers. This policy does not apply to DBH certified/contracted substance use disorder (SUD) services providers which use the Treatment Assignment Protocol (TAP) to determine LOC, and the child and youth mental health providers which utilize the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS).

**Policy Clearance.** Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices.

**Effective Date**. This policy is effective November 01, 2014.

**Superseded Policy.** This policy replaces DMH Policy 300.1D, Level of Care Utilization System (LOCUS/CALOCUS) Evaluations, dated February 27, 2012.

**Distribution.** This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.



10/30/14

**Stephen T. Baron**
**Director, DBH**

| GOVERNMENT OF THE DISTRICT OF COLUMBIA<br>DEPARTMENT OF BEHAVIORAL HEALTH | Policy No.<br>300.1 | Date<br>OCT 01 2014 | Page 1 |
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| | Supersedes:<br>DMH Policy 300.1D, Level of Care Utilization System (LOCUS/CALOCUS) Evaluations, dated Feb. 27, 2012 | | |

**Subject: Level of Care Determination for Adults in MHRS**

1. **Purpose**. To establish policy and procedures in utilizing the Department of Behavioral Health's (DBH) approved tool for level of care (LOC) determination for all adult consumers enrolled in a core services agency (CSA). This version has removed the Child and Adolescent Level of Care Utilization System (CALOCUS) component and refers to the Child and Adolescent Functional Assessment Scale (CAFAS) and the Preschool and Early Childhood Functional Assessment Scale (PECFAS) for functional assessment.

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3. **Authority**. DBH Establishment Act of 2013 and 22 DCMR A34 Mental Health Rehabilitation Services (MHRS) Provider Certification Standards.

4. **Definitions**.

4a. Active Adult Consumer. A consumer age eighteen (18) or older who is enrolled with a CSA, receiving mental health treatment and services in accordance with his/her Individual Recovery Plan (IRP). Adults, ages 18 – 20, may be assessed using CAFAS instead of LOCUS if they are receiving mental health services through child, youth and family Programs (see DBH Policy # 300.2 Functional Assessments for Children and Youth).

4b. Assertive Community Treatment (ACT). An intensive, integrated, rehabilitative, treatment and community-based service provided by an interdisciplinary team to adults with serious and persistent mental illness.

4c. Level of Care (LOC). A determination of an individual's need for intensity or type of services.

4d. Level Of Care Utilization System (LOCUS). The DBH approved clinical evaluation tool that determines the level of care (LOC) for adults based on their level of functioning, in addition to diagnosis and psychiatric risks (see LOCUS Levels of Care Definitions in Exhibit 1 and Abbreviated Manual and Scoring Protocol in Exhibit 2).

4e. Mental Health Community Residence Facility (MHCRF). A DBH licensed, publicly or privately owned, residence that houses individuals, eighteen (18) or older, with a principal

diagnosis of mental illness that require twenty four (24) hour on-site supervision, personal assistance, lodging, and meals and who are not in the custody of the DC Department of Corrections.

4f. Child and Adolescent Functional Assessment Scale (CAFAS). A rating scale which assesses functional impairment in youth ages 6 -20 in DBH. This assessment is repeated every 90 days to monitor progress or improvement over time in the following areas: behavioral, emotional, psychological or substance abuse disorders.

4g. Preschool and Early Childhood Functional Assessment Scale (PECFAS). The version of the CAFAS which applies to 3 – 5 years old in DBH, which assesses a child's day-to-day functioning across critical life domains and determines whether a child's functioning. This assessment is conducted every 90 days to monitor progress or improvement over time.

4h. Treatment Assignment Protocol (TAP). A clinical evaluation tool utilized by SUD providers to determine LOC.

5. **Policy**. To ensure that services are individualized, clinically appropriate, and least restrictive, all adult consumers enrolled in a CSA and engaged in active treatment shall be assessed for their level of functioning and intensity of services.

5a. LOCUS evaluations shall be used as part of the treatment planning process to assist in determining the appropriate LOC for the consumer. Treatment interventions are based on individualized clinical assessment.

5b. The use of the DBH web-based LOCUS is mandatory in the following circumstances (see Section 6): at intake, during the development of a treatment plan and when the consumer is in crisis and/or a level of care change is required.

5c. The LOCUS results shall be part of the consumer's clinical record and shall be accessible in treatment planning.

5d. LOCUS rating shall not be used to force treatment or services or deter consumer choice.

5e. A consumer may or may not receive services designated in the LOC depending on the clinical assessment. DBH authorization is required for some services prior to delivery.

5f. Data gathered from the web-based LOCUS application shall be utilized for system monitoring, quality improvement and performance evaluation as outlined in the LOCUS Data Reporting and Quality Improvement Plan maintained by the DBH Office of Accountability.

6. **Procedures**. A LOCUS evaluation shall be completed in accordance with the following:

6a. Core Services Agency (CSA). The CSA shall perform a LOCUS in the following circumstances:

(1) At intake. Consumers presenting for intake at a CSA shall have a LOCUS evaluation completed by the CSA, with collateral information, as much as possible, from persons

and/or entities that had contact with the consumer within, at least, the last thirty (30) days.

(2) Continuing treatment. Consumers in continuing treatment at a CSA shall have a LOCUS evaluation completed by the CSA at a minimum of every 180 days (every 6 months) in conjunction with the consumer's Individual Recovery Plan (IRP). If the consumer is receiving ACT services, the ACT provider is responsible for the development of the LOCUS and the IRP (see section 6b below).

(3) Residence transfers. The CSA shall complete a LOCUS evaluation whenever a consumer is recommended for transfer to a MHCRF or to a different level of MHCRF (Supported Residence, Supportive Rehabilitative Residence or Intensive Residence). Once transferred, the CSA shall conduct a LOCUS in conjunction with the new treatment plan and every 180 days thereafter.

(4) Consumers at Saint Elizabeths Hospital. The CSA shall complete a LOCUS evaluation with input from the hospital's treatment planning team prior to and as part of the discharge planning to determine acuity and level of care for adult consumers at Saint Elizabeths Hospital in civil and forensic programs.

(5) Consumers who are incarcerated. The CSA, with input from the mental health staff at Central Detention Facility (CDF/DC Jail), shall complete a LOCUS evaluation upon initial assessment of the consumer, and prior to release, when notified.

(6) As clinically indicated. The CSA shall complete a LOCUS any time the consumer experiences significant events affecting his/her functioning that would impact service intensity (e.g., visit to crisis emergency provider or hospitalization).

6b. Specialty Providers. For consumers enrolled in a CSA and referred to a specialty provider (e.g., ACT), the specialty provider shall complete the LOCUS.

(1) Assertive Community Treatment (ACT). The CSA conducts the LOCUS evaluation for referral to ACT. Then, the ACT provider shall complete the LOCUS evaluation every 180 days thereafter or, as clinically indicated.

(2) Crisis Bed Provider. If a consumer is referred to a crisis bed and the crisis is not resolved within 48 hours, the crisis bed provider staff shall provide a completed LOCUS to Access Helpline (AHL), along with a psychiatric evaluation and a clinical presentation to obtain initial authorization from DBH for continued stay.

6c. DBH Office of Programs and Policy (OPP).

(1) Training. The OPP shall provide the LOCUS tool and training for the completion of the web-based assessment tools to CSA, sub and specialty provider staff.

(2) Account set-up. After a LOCUS user is trained, an account request form shall be completed and sent to the DBH Division of Provider Relations in order to establish access to the web-based LOCUS tools.

(3) Account Confirmation. The Division of Provider Relations shall confirm the accuracy of information and level of web access designation, and forward the request to the Division of Information Services to create the user account.

(4) LOCUS Web Access. Authorized users may access the web-based LOCUS evaluation tool at: http://locus.dmh.dc.gov/

6d. DBH Office of Accountability shall:

(1) Monitor implementation to ensure that LOCUS evaluations are completed accurately and timely in compliance with this policy.

(2) Conduct quality reviews and develop agency and system-level quality monitoring and improvement activities.

(3) Develop quality improvement initiatives or corrective action plans, as necessary, to improve the quality of the evaluations or compliance with this policy.

7. **Updates**. Updates, if any, shall be provided through the Provider Bulletins on the DBH website.

8. **Inquiries**. Contact the Division of Provider Relations or Office of Programs and Policy.

9. **Exhibits**.

Exhibit 1 – Levels of Care Definitions (LOCUS)
Exhibit 2 – LOCUS Abbreviated Manual & Scoring Protocol

**Approved by:**

**Stephen T. Baron**
**Director, DBH**

10/31/14

**(Signature)** **(Date)**

**LEVELS OF CARE DEFINITIONS (LOCUS)**
(An Excerpt from the LOCUS Adult Version 2010, AACP, Deerfield Behavioral Health, Inc., March 20, 2009).

## BASIC SERVICES - Prevention and Health Maintenance

### Definition:

Basic services are designed to prevent the onset of illness or to limit the magnitude of morbidity associated with already established disease processes. These services may be developed for individual or community application, and are generally carried out in a variety of community settings. These services will be available to all members of the community with special focus on children.

1. **Care Environment** - An easily accessible office and communications equipment. Adequate space for any services provided on-site must be available. Central offices are likely to be most conveniently located in or near a community health center. Most services will be provided in the community, however, in schools, places of employment, community centers, libraries, churches, etc., and transportation capabilities must be available.

2. **Clinical Services** - Twenty-four hour physician and nursing capabilities will be provided for emergency evaluation, brief intervention, and outreach services.

3. **Support Services** - As needed for crisis stabilization, having the capability to mobilize community resources and facilitate linkage to more intense levels of care if needed.

4. **Crisis Stabilization and Prevention Services** - In addition to crisis services already described, prevention programs would be available and promoted for all covered members. These programs would include: 1) Community outreach to special populations such as the homeless, elderly, children, pregnant woman, disrupted or violent families and criminal offenders; 2) Debriefing for victims of trauma or disaster; 3) Frequent opportunities to screen for high risk members in the community; 4) Health maintenance education (e.g., coping skills, stress management, recreation); 5) Violence prevention education and community organization; 6) Consultation to primary care providers and community groups; 7) Facilitation of mutual support networks and empowerment programs; 8) Environmental evaluation programs identifying mental health toxins; and 9) Support of day care and child enrichment programs.

### Placement Criteria:

These Basic Services should be available to all members of the community regardless of their status in the dimensional rating scale.

## I. LEVEL ONE - Recovery Maintenance and Health Management

### Definition:

**LEVELS OF CARE DEFINITIONS (LOCUS)**
(An Excerpt from the LOCUS Adult Version 2010, AACP, Deerfield Behavioral Health, Inc., March 20, 2009).

**1. Care Environment** - Services may be provided within the confines of a clinic setting providing adequate space for provision of services available at this level, or they may in some cases be provided by wrapping services around the client in the community (i.e. ACT team).

**2. Clinical Services** - Clinical services should be available to clients throughout most of the day on a daily basis. Psychiatric services would be accessible on a daily basis and contact would occur as required by initial and ongoing assessment. Psychiatric services would also be available by remote communication on a 24-hour basis. Nursing services should be available about 40 hours per week. Physical assessment should be provided on-site if possible and access to ongoing primary medical care should be available. Intensive treatment should be provided at least five days per week and include individual, group, and family therapy depending on client needs. Rehabilitative services will be an integral aspect of the treatment program. Medication can be carefully monitored, but in most cases will be self-administered.

**3. Supportive Services** - Case management services will be integrated with onsite treatment teams or mobile treatment teams and will provide assistance with providing or arranging financial support, supportive housing, systems management, transportation and ADL maintenance. Liaison with mutual support networks and individual groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.

**4. Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, as will other Basic Services.

**Placement Criteria:**

**1. Risk of Harm** - a rating of three or less is required for placement at this level independent of other variables, and a rating higher than three should not be managed at this level.

**2. Functional Status** - a rating of three is most appropriate for this level of care independent of other variables. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment (ACT) would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).

**3. Co-Morbidity** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in that circumstance).

**7. Composite Rating** - placement at this level of care implies that the client has successfully completed treatment at a more intensive level of care and primarily needs assistance in maintaining gains realized in the past. A composite rating of more than 10 but less than 14 should generally be obtained for eligibility for this service.

## II. LEVEL TWO - Low Intensity Community Based Services

### Definition:

This level of care provides treatment to clients who need ongoing treatment, but who are living either independently or with minimal support in the community. Treatment and service needs do not require intense supervision or very frequent contact. Programs of this type have traditionally been clinic-based programs. These programs must provide the following:

**1. Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but the way out cannot be restricted. In some cases services may be provided in community locations or in the place of residence.

**2. Clinical Services** - Treatment programming will be available up to three hours per week, but usually not less than one hour every two weeks. Psychiatric or physician review and/or contact should be available according to need as indicated by initial and ongoing assessment. Medication use can be monitored and managed in this setting. Capabilities to provide individual, group, and family therapies should be available in these settings.

**3. Supportive Services** - Case management services will generally not be required at this level of care, but assistance with arranging financial support, supportive housing, systems management, and transportation may be necessary. Liaison with mutual support networks and individual advocacy groups, and coordination with educational or vocational programming will also be available according to client needs.

**4. Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Educational and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. In addition, all other Basic Services will be accessible.

### Placement Criteria:

**1. Risk of Harm** - a rating of two or less would be most appropriate for this level of care. In some cases, a rating of three could be accommodated if the composite rating falls within guidelines.

**2. Functional Status** - ratings of three or less could be managed at this level.

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**3. Co-Morbidity** - a rating of two or less is required for placement at this level.

**4. Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the "A" and "B" scales is required for treatment at this level.

**5. Treatment and Recovery History** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three could be attempted at this level if stepping down from a more intensive level of care and a rating of two or less is obtained on scale "B" of dimension four.

**6. Engagement and Recovery Status** - a rating of two or less is generally most appropriate for this level of care. In some cases, a rating of three may be placed at this level if unwilling to participate in treatment at a more intensive level.

**7. Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 14 but no more than 16 is required for treatment at this level.

## III. LEVEL THREE - High Intensity Community Based Services

**Definition:**

This level of care provides treatment to clients who need intensive support and treatment, but who are living either independently or with minimal support in the community. Service needs do not require daily supervision, but treatment needs require contact several times per week. Programs of this type have traditionally been clinic based programs. These programs must provide the following:

**1. Care Environment** - Adequate space should be available to carry out activities required for treatment. Space should be easily accessible, well ventilated and lighted. Access to the facility can be monitored and controlled, but egress cannot be restricted. These services may be provided in community locations in some cases, including the place of residence.

**2. Clinical Services** - Treatment programming (including group, individual and family therapy) will be available about three days per week and about two or three hours per day. Psychiatric/medical staffing should be adequate to provide review and/or contact as needed according to initial and ongoing assessment. On call psychiatric/medical services will generally not be available on a 24-hour basis. Skilled nursing care is usually not required at this level of care, and medication use can be monitored but not administered. Capabilities to provide individual, group, family and rehabilitative therapies should be available in these settings.

**3. Supportive Services** - Case management or outreach services should be available and integrated with treatment teams. Assistance with providing or arranging financial support, supportive housing, systems management and transportation should be available. Liaison with mutual support networks and individual advocacy groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.

**4. Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, and access to these services will be facilitated. All other Basic Services will also be available.

**Placement Criteria:**

**1. Risk of Harm** - a rating of three or less can be managed at this level.

**2. Functional Status** - a rating of three or less is required for this level of care.

**3. Co-Morbidity** - a rating of three or less can be managed at this level of care.

**4. Recovery Environment** - a rating of three or less on each scale and a combined score of no more than five on the "A" and "B" scales is required for treatment at this level.

**5. Treatment and Recovery History** - a rating of two is most appropriate for management at this level of care, but in many cases a rating of three can be accommodated.

**6. Engagement and Recovery Status** - a rating of three or less is required for this level of care.

**7. Composite Rating** - placement at this level of care will generally be determined by the interaction of a variety of factors, but will be excluded by a score of four or more on any dimension. A composite score of at least 17 and no more than 19 is required for treatment at this level.

## IV. LEVEL FOUR - Medically Monitored Non-Residential Services

This level of care refers to services provided to clients capable of living in the community either in supportive or independent settings, but whose treatment needs require intensive management by a multi disciplinary treatment team. Services, which would be included in this level of care, have traditionally been described as partial hospital programs and as assertive community treatment programs.

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**1. Care Environment** - Services may be provided within the confines of a clinic setting providing adequate space for provision of services available at this level, or they may in some cases be provided by wrapping services around the client in the community (i.e. ACT team).

**2. Clinical Services** - Clinical services should be available to clients throughout most of the day on a daily basis. Psychiatric services would be accessible on a daily basis and contact would occur as required by initial and ongoing assessment. Psychiatric services would also be available by remote communication on a 24-hour basis. Nursing services should be available about 40 hours per week. Physical assessment should be provided on-site if possible and access to ongoing primary medical care should be available. Intensive treatment should be provided at least five days per week and include individual, group, and family therapy depending on client needs. Rehabilitative services will be an integral aspect of the treatment program. Medication can be carefully monitored, but in most cases will be self-administered.

**3. Supportive Services** - Case management services will be integrated with onsite treatment teams or mobile treatment teams and will provide assistance with providing or arranging financial support, supportive housing, systems management, transportation and ADL maintenance. Liaison with mutual support networks and individual groups, facilitation of recreational and social activities, and coordination with educational or vocational programming will also be available according to client needs.

**4. Crisis Stabilization and Prevention Services** - Clients must have access to 24-hour emergency evaluation and brief intervention services including a respite environment. Mobile service capability, day care and child enrichment programs, education and employment opportunities, and empowerment programs will be available, as will other Basic Services.

**Placement Criteria:**

**1. Risk of Harm** - a rating of three or less is required for placement at this level independent of other variables, and a rating higher than three should not be managed at this level.

**2. Functional Status** - a rating of three is most appropriate for this level of care independent of other variables. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment (ACT) would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).

**3. Co-Morbidity** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in that circumstance).

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**4. Recovery Environment** - an "A" scale rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "B". (Availability of Assertive Community Treatment would merit a rating of one on scale "B"). A "B" scale rating of three or less could otherwise generally be managed at this level.

**5. Treatment and Recovery History** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).

**6. Engagement and Recovery Status** - a rating of three or less is most appropriate for this level of care. In some cases, a rating of four could be managed at this level if placed in conjunction with a rating of one on scale "A" and "B" in dimension four. (Availability of Assertive Community Treatment would be equivalent to a rating of one on scale "B". An "A" scale rating of two could generally be managed in conjunction with ACT).

**7. Composite Rating** - in many cases, utilization of this level of care will be determined by the interaction of a variety of factors. A composite rating of 20 requires treatment at this level with or without ACT resources available. (The presence of ACT reduces scores on dimension four enabling these criteria to be met even when scores of four are obtained in other dimensions.)

**V. LEVEL FIVE - Medically Monitored Residential Services**

**Definition:**

This level of care refers to residential treatment provided in a community setting. This level of care has traditionally been provided in non-hospital, free standing residential facilities based in the community. In some cases, longer-term care for persons with chronic, non-recoverable disability, which has traditionally been provided in nursing homes or similar facilities, may be included at this level. Level five services must be capable of providing the following:

**1. Care Environment** - Facilities will provide adequate living space for all residents and be capable of providing reasonable protection of personal safety and property. Physical barriers preventing egress or access to the community may be used at this level of care but facilities of this type will generally not allow the use of seclusion or restraint. Food services must be available or adequate provisions for residents to purchase and prepare their food must be made.

**2. Clinical Capabilities** - Access to clinical care must be available at all times. Psychiatric care should be available either on site or by remote communication 24 hours daily and psychiatric consultation should be available on site at least weekly, but client contact may be required as

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often as daily. Emergency medical care services should be easily and rapidly accessible. On site nursing care should be available about 40 hours per week if medications are being administered on a frequent basis. Onsite treatment should be available seven days a week including individual, group and family therapy. In addition, rehabilitation and educational services must be available either on or off site. Medication is monitored, but does not necessarily need to be administered to residents in this setting.

**3. Supportive Services** - Residents will be provided with supervision of activities of daily living, and custodial care may be provided to designated populations at this level. Staff will facilitate recreational and social activities and coordinate interface with educational and rehabilitative programming provided off site.

**4. Crisis Resolution and Prevention** - Residential treatment programs must provide services facilitating return to community functioning in a less restrictive setting. These services will include coordination with community case managers, family and community resource mobilization, liaison with community based mutual support networks, and development of transition plan to supportive environment.

**Placement Criteria:**

**1. Risk of Harm** - a rating of four requires care at this level independently of other parameters.

**2. Functional Status** - a rating of four requires care at this level independently of other dimensional ratings, with the exception of some clients who are rated at one on dimension four on both scale "A" and "B" (see level three criteria).

**3. Co-Morbidity** - a rating of four requires care at this level independently of other parameters, with the exception of some clients who are rated at one on dimension four on both scale "A" and "B" (see level three criteria).

**4. Recovery Environment** - a rating of four or higher on the "A" and "B" scale and in conjunction with a rating of at least three on one of the first three dimensions requires care at this level.

**5. Treatment and Recovery History** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.

**6. Engagement and Recovery Status** - a rating of three or higher in conjunction with a rating of at least three on one of the first three dimensions requires treatment at this level.

**7. Composite Rating** - while a client may not meet any of the above independent ratings, in some circumstances, a combination of factors may require treatment in a more structured setting. This would generally be the case for clients who have a composite rating of 24 or higher.

**LEVELS OF CARE DEFINITIONS (LOCUS)**
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## VI. LEVEL SIX - Medically Managed Residential Services

**Definition:**

This is the most intense level of care in the continuum. Level six services have traditionally been provided in hospital settings, but could, in some cases, be provided in freestanding non-hospital settings. Whatever the case may be, such settings must be able to provide the following:

**1. Care Environment** - The facility must be capable of providing secure care, usually meaning that clients should be contained within a locked environment (this may not be necessary for services such as detoxification, however) with capabilities for providing seclusion and/or restraint if necessary. It should be capable of providing involuntary care when called upon to do so. Facilities must provide adequate space, light, ventilation, and privacy. Food services and other personal care needs must be adequately provided.

**2. Clinical Services** - Clinical services must be available 24 hours a day, seven days a week. Psychiatric, nursing, and medical services must be available on site, or in close enough proximity to provide a rapid response, at all times. Psychiatric/medical contact will generally be made on a daily basis. Treatment will be provided on a daily basis and would include individual, group and family therapy as well as pharmacologic treatment, depending on the client's needs.

**3. Supportive Services** - All necessities of living and well being must be provided for clients treated in these settings. When capable, clients will be encouraged to participate in and be supported in efforts to carry out activities of daily living such as hygiene, grooming and maintenance of their immediate environment.

**4. Crisis Resolution and Prevention Services** – These residential settings must provide services designed to reduce the stress related to resuming normal activities in the community. Such services might include coordination with community case managers, family and community resource mobilization, environmental evaluation and coordination with residential services, and coordination with and transfer to less intense levels of care.

**Placement Criteria:**

**1. Risk of Harm** - a rating of five qualifies an admission independently of other parameters.

**2. Functional Status** - a rating of five qualifies placement independently of other variables.

**3. Medical and Psychiatric Co-Morbidity** - a rating of five qualifies placement independently of other parameters.

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**4. Recovery Environment** - a rating of four or more would be most appropriate for this level, but no rating in this parameter qualifies placement independently at this level, nor would it disqualify placement if otherwise warranted.

**5. Treatment and Recovery History** - a rating of four or more would be most appropriate for this level but, no rating in this dimension qualifies placement independently at this level, nor would it disqualify an otherwise warranted placement.

**6. Engagement and Recovery Status** - a rating of four or more would be most appropriate for this level but no rating in this parameter qualifies or disqualifies placement independently at this level.

**7. Composite Rating** - in some cases, patients not meeting independent criteria in any one category, may still need treatment at this level if ratings in several categories are high, thereby increasing the risk of treatment in a less intensive setting. A composite rating of 28 (an average rating of four or more in each dimension) would indicate the need for treatment at this level.

DBH Policy 300.1
Exhibit 2 (4e)

# LOCUS ABBREVIATED MANUAL & SCORING PROTOCOL

(For use when a computer is not available. Transfer scores from this sheet to the web-based system)

**Consumer Name:** _____ **eCura ID** ☐

**Date of Evaluation:** _____ **Name of Clinician/Worker:** _____

| | | |
|---|---|---|
| A. | **Previous** Level of Care Recommendation (1, 2, 3, 4, 5 or 6) | ☐ |
| B. | **Previous** Composite LOCUS Score (6 to 28+) | ☐ |

## Level of Care Utilization System (LOCUS)

| Dimension | Rating | Criteria Selected (Write in "a, b, c, d and/or e") |
|---|---|---|
| **1. Risk of Harm** | 1 2 3 **4*** **5** | ☐☐☐☐☐ |
| **2. Functional Status** | 1 2 3 **4*** **5** | ☐☐☐☐☐ |
| **3. Co-Morbidity** | 1 2 3 **4*** **5** | ☐☐☐☐☐ |
| 4. Recovery Environment | | |
| 4a. Level of Stress | 1 2 3 4 5 | ☐☐☐☐☐ |
| 4b. Level of Support | 1 2 3 4 5 | ☐☐☐☐☐ |
| 5. Treatment and Recovery History | 1 2 3 4 5 | ☐☐☐☐☐ |
| 6. Engagement and Recovery Status | 1 2 3 4 5 | ☐☐☐☐☐ |

*(Note: **Bold** indicates independent criteria domains. A score of 4 results in placement at level 5 and a score of 5 results in placement at level six regardless of combined score.). * = independent criteria that may be waived if sum of 4a and 4b scores equal 2 (Low Stress Environment).*
*(Note: For question 4, please record the higher of the two scores)*

C. COMPOSITE LOCUS SCORE (Use web-based system to score accurately) ☐

D. LOCUS Derived Level of Care Recommendation (Use web-based system to score accurately) ☐

E. Actual Level of Care (if different from recommended Level of Care) ☐

Reason for Variance from LOCUS Derived Level of Care Recommendation:

_____

_____

_____

_____

_____

(Adapted from the American Association of Community Psychiatrists LOCUS – Level of Care Utilization System for Psychiatric and Addiction Services Manual, Adult Version 2010)

**DIMENSION I. RISK OF HARM**

This dimension of the assessment considers a person's potential to cause significant harm to self or others. While this may most frequently be due to suicidal or homicidal thoughts or intentions, in many cases unintentional harm may result from misinterpretations of reality, from inability to adequately care for one's self, or from altered states of consciousness due to use of intoxicating substances in an uncontrolled manner. For the purposes of evaluation in this parameter, deficits in ability to care for one's self are considered only in the context of their potential to cause harm. Likewise, only behaviors associated with substance use are used to rate risk of harm, not the substance use itself. In addition to direct evidence of potentially dangerous behavior from interview and observation, other factors may be considered in determining the likelihood of such behavior such as; past history of dangerous behaviors, inability to contract for safety (while contracting for safety does not guarantee it, the inability to do so increases concern), and availability of means. When considering historical information, recent patterns of behavior should take precedence over patterns reported from the remote past. Risk of harm may be rated according to the following criteria:

☐ **MINIMAL RISK OF HARM**

- ☐ No indication of suicidal or homicidal thoughts or impulses, and no history of suicidal or homicidal ideation, and no indication of significant distress.
- ☐ Clear ability to care for self now and in the past.

☐ **LOW RISK OF HARM**

- ☐ No current suicidal or homicidal ideation, plan, intentions or severe distress, but may have had transient or passive thoughts recently or in the past.
- ☐ Occasional substance use without significant episodes of potentially harmful behaviors.
- ☐ Periods in the past of self-neglect without current evidence of such behavior.

☐ **MODERATE RISK OF HARM**

- ☐ Significant current suicidal or homicidal ideation without intent or conscious plan and without past history.
- ☐ No active suicidal/homicidal ideation, but extreme distress and/or a history of suicidal/homicidal behavior exists.
- ☐ History of chronic impulsive suicidal/homicidal behavior or threats, but current expressions do not represent significant change from usual behavior.
- ☐ Binge or excessive use of substances resulted in potentially harmful behaviors in the past, but there have been no recent episodes.
- ☐ Some evidence of self-neglect and/or decrease in ability to care for one's self in current environment.

☐ **SERIOUS RISK OF HARM**

- ☐ Current suicidal or homicidal ideation with expressed intentions and/or past history of carrying out such behavior but without means for carrying out the behavior, or with some expressed inability or aversion to doing so, or with ability to contract for safety.
- ☐ History of chronic impulsive suicidal/homicidal behavior or threats with current expressions or behavior representing a significant elevation from usual behavior.
- ☐ Recent pattern of excessive substance use resulting in loss of self-control and clearly harmful behaviors with no demonstrated ability to abstain from use.
- ☐ Clear compromise of ability to care adequately for one's self or to be adequately aware of environment.

(Adapted from the American Association of Community Psychiatrists LOCUS – Level of Care Utilization System for Psychiatric and Addiction Services Manual, Adult Version 2010)

☐ **EXTREME RISK OF HARM**

- ☐ Current suicidal or homicidal behavior or such intentions with a plan and available means to carry out this behavior…
  - without expressed ambivalence or significant barriers to doing so, or
  - with a history of serious past attempts which are not of a chronic, impulsive or consistent nature, or
  - in presence of command hallucinations or delusions which threaten to override usual impulse control.
- ☐ Repeated episodes of violence toward self or others, or other behaviors resulting in harm while under the influence of intoxicating substances with pattern of nearly continuous and uncontrolled use.
- ☐ Extreme compromise of ability to care for one's self or to adequately monitor environment with evidence of deterioration in physical condition or injury related to these deficits.

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**DIMENSION II. FUNCTIONAL STATUS**

This dimension of the assessment measures the degree to which a person is able to fulfill social responsibilities, to interact with others, maintain their physical functioning (such as sleep, appetite, energy, etc.), as well as a person's capacity for self-care. This ability should be compared against an ideal level of functioning given an individual's limitations, or may be compared to a baseline functional level as determined for an adequate period of time prior to onset of this episode of illness. Persons with ongoing, longstanding deficits who do not experience any acute changes in their status are the only exception to this rule and are given a rating of three. If such deficits are severe enough that they place the client at risk of harm, they will be considered when rating Dimension I in accord with the criteria elaborated there. For the purpose of this document, sources of impairment should be limited to those directly related to psychiatric and/or addiction problems that the individual may be experiencing. While other types of disabilities may play a role in determining what types of support services may be required, they should generally not be considered in determining the placement of a given individual in the behavioral treatment continuum.

☐ **MINIMAL IMPAIRMENT**

- ☐ No more than transient impairment in functioning following exposure to an identifiable stressor.

☐ **MILD IMPAIRMENT**

- ☐ Experiencing some problems in interpersonal interactions, with increased irritability, hostility or conflict, but is able to maintain some meaningful and satisfying relationships.
- ☐ Recent experience of some minor disruptions in aspects of self-care or usual activities.
- ☐ Developing minor but consistent difficulties in social role functioning and meeting obligations such as difficulty fulfilling parental responsibilities or performing at expected level in work or school, but maintaining ability to continue in those roles.
- ☐ Demonstrating significant improvement in function following a period of difficulty.

☐ **MODERATE IMPAIRMENT**

- ☐ Recently conflicted, withdrawn, alienated or otherwise troubled in most significant relationships, but maintains control of any impulsive, aggressive or abusive behaviors.
- ☐ Appearance and hygiene falls below usual standards on a frequent basis.
- ☐ Significant disturbances in physical functioning such as sleep, eating habits, activity level, or sexual appetite, but without a serious threat to health.

- ☐ Significant deterioration in ability to fulfill responsibilities and obligations to job, school, self, or significant others and these may be avoided or neglected on some occasions.
- ☐ Ongoing and/or variably severe deficits in interpersonal relationships, ability to engage in socially constructive activities, and ability to maintain responsibilities.
- ☐ Recent gains and/or stabilization in function have been achieved while participating in treatment in a structured and/or protected setting.

☐ **SERIOUS IMPAIRMENT**

- ☐ Serious decrease in the quality of interpersonal interactions with consistently conflicting or otherwise disrupted relations with others, which may include impulsive, aggressive or abusive behaviors.
- ☐ Significant withdrawal and avoidance of almost all social interaction.
- ☐ Consistent failure to maintain personal hygiene, appearance, and self-care near usual standards.
- ☐ Serious disturbances in physical functioning such as weight change, disrupted sleep, or fatigue that threaten physical well being.
- ☐ Inability to perform close to usual standards in school, work, parenting, or other obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time.

☐ **SEVERE IMPAIRMENT**

- ☐ Extreme deterioration in social interactions which may include chaotic communication, threatening behaviors with little or no provocation, or minimal control of impulsive, aggressive or otherwise abusive behavior.
- ☐ Development of complete withdrawal from all social interactions.
- ☐ Complete neglect of personal hygiene and appearance and inability to attend to most basic needs such as food intake and personal safety with associated impairment in physical status.
- ☐ Extreme disruptions in physical functioning causing serious harm to health and well being.
- ☐ Complete inability to maintain any aspect of personal responsibility as a citizen, or in occupational, educational, or parental roles.

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**DIMENSION III. MEDICAL, ADDICTIVE, and PSYCHIATRIC CO-MORBIDITY**

This dimension measures potential complications in the course of illness related to co-existing medical illness, substance use disorder, or psychiatric disorder in addition to the condition first identified or most readily apparent (here referred to as the presenting disorder). Co-existing disorders may prolong the course of illness in some cases, or may necessitate availability of more intensive or more closely monitored services in other cases. Unless otherwise indicated, historical existence of potentially interacting disorders should not be considered in this parameter unless current circumstances would make reactivation of those disorders likely. For patients who present with substance use disorders, physiologic withdrawal states should be considered to be medical co-morbidity for scoring purposes.

☐ **NO CO-MORBIDITY**

- ☐ No evidence of medical illness, substance use disorders, or psychiatric disturbances apart from the presenting disorder.
- ☐ Any illnesses that may have occurred in the past are now stable and pose no threat to the stability of the current condition.

☐ **MINOR CO-MORBIDITY**

- ☐ Existence of medical problems which are not themselves immediately threatening or debilitating and which have no impact on the course of the presenting disorder.
- ☐ Occasional episodes of substance misuse, but any recent episodes are self-limited, show no pattern of escalation, and there is no indication that they adversely affect the course of a co-existing psychiatric disorder.
- ☐ May occasionally experience psychiatric symptoms which are related to stress, medical illness, or substance use, but these are transient and have no detectable impact on a co-existing substance use disorder.

☐ **SIGNIFICANT CO-MORBIDITY**

- ☐ Medical conditions exist, or have potential to develop (such as diabetes or a mild physiologic withdrawal syndrome), which may require significant medical monitoring.
- ☐ Medical conditions exist which may be created or adversely affected by the existence of the presenting disorder.
- ☐ Medical conditions exist which may adversely affect the course of the presenting disorder.
- ☐ Ongoing or episodic substance use occurring despite negative consequences with significant or potentially significant negative impact on the course of any co-existing psychiatric disorder.
- ☐ Recent substance use which has had clearly detrimental effects on the presenting disorder but which has been temporarily arrested through use of a highly structured or protected setting or through other external means.
- ☐ Significant psychiatric symptoms and signs are present which are themselves somewhat debilitating, and which interact with and have an adverse affect on the course and severity of any co-existing substance use disorder.

☐ **MAJOR CO-MORBIDITY**

- ☐ Medical conditions exist, or have a very high likelihood of developing (such as a moderate, but uncomplicated, alcohol, sedative, or opiate withdrawal syndrome, mild pneumonia, or uncontrolled hypertension), which may require intensive, although not constant, medical monitoring.
- ☐ Medical conditions exist which are clearly made worse by the existence of the presenting disorder.
- ☐ Medical conditions exist which clearly worsen the course and outcome of the presenting disorder.
- ☐ Uncontrolled substance use occurs at a level, which poses a serious threat to health if unchanged, and/or which poses a serious barrier to recovery from any co-existing psychiatric disorder.
- ☐ Psychiatric symptoms exist which are clearly disabling and which interact with and seriously impair ability to recover from any co-existing substance use disorder.

☐ **SEVERE CO-MORBIDITY**

- ☐ Significant medical conditions exist which may be poorly controlled and/or potentially life threatening in the absence of close medical management (e.g., severe or complicated alcohol withdrawal, uncontrolled diabetes mellitus, complicated pregnancy, severe liver disease, debilitating cardiovascular disease).
- ☐ Presence and lack of control of presenting disorder places client in imminent danger from complications of existing medical problems.

(Adapted from the American Association of Community Psychiatrists LOCUS – Level of Care Utilization System for Psychiatric and Addiction Services Manual, Adult Version 2010)

- ☐ Uncontrolled medical condition severely worsens the presenting disorder, dramatically prolonging the course of illness and seriously impeding the ability to recover from it.
- ☐ Severe substance dependence with inability to control use under any circumstance and which may include intense withdrawal symptoms or continuing use despite clear worsening of any co-existing psychiatric disorder and other aspects of well being.
- ☐ Acute or severe psychiatric symptoms are present which seriously impair client's ability to function and prevent recovery from any co-existing substance use disorder, or seriously worsen it.

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**DIMENSION IV. RECOVERY ENVIRONMENT**

This dimension considers factors in the environment that may contribute to the onset or maintenance of addiction or mental illness, and factors that may support a person's efforts to achieve or maintain mental health and/or abstinence. Stressful circumstances may originate from multiple sources and include interpersonal conflict or torment, life transitions, losses, worries relating to health and safety, and ability to maintain role responsibilities. Supportive elements in the environment are resources which enable persons to maintain health and role functioning in the face of stressful circumstances, such as availability of adequate material resources and relationships with family members. The availability of friends, employers or teachers, clergy and professionals, and other community members that provide caring attention and emotional comfort, are also sources of support. For persons being treated in locked or otherwise protected residential settings, ratings should be based on the conditions that would be encountered upon transitioning to a new or returning to the usual environment, whichever is most appropriate to the circumstances.

***LEVEL OF STRESS:***

☐ **LOW STRESS ENVIRONMENT**

- ☐ Essentially no significant or enduring difficulties in interpersonal interactions and significant life circumstances are stable.
- ☐ No recent transitions of consequence.
- ☐ No major losses of interpersonal relationships or material status have been experienced recently.
- ☐ Material needs are met without significant cause for concern that they may diminish in the near future, and no significant threats to health or safety are apparent.
- ☐ Living environment poses no significant threats or risk.
- ☐ No pressure to perform beyond capacity in social role.

☐ **MILDLY STRESSFUL ENVIRONMENT**

- ☐ Presence of some ongoing or intermittent interpersonal conflict, alienation, or other difficulties.
- ☐ A transition that requires adjustment such as change in household members or a new job or school.
- ☐ Circumstances causing some distress such as a close friend leaving town, conflict in or near current residence, or concern about maintaining material well being.
- ☐ A recent onset of a transient but temporarily disabling illness or injury.
- ☐ Potential for exposure to alcohol and/or drug use exists.*
- ☐ Performance pressure (perceived or actual) in school or employment situations creating discomfort.

☐ **MODERATELY STRESSFUL ENVIRONMENT**

- ☐ Significant discord or difficulties in family or other important relationships or alienation from social interaction.
- ☐ Significant transition causing disruption in life circumstances such as job loss, legal difficulties or change of residence.

- ☐ Recent important loss or deterioration of interpersonal or material circumstances.
- ☐ Concern related to sustained decline in health status.
- ☐ Danger in or near habitat.
- ☐ Easy exposure and access to alcohol and drug use. *
- ☐ Perception that pressure to perform surpasses ability to meet obligations in a timely or adequate manner.

☐ **HIGHLY STRESSFUL ENVIRONMENT**

- ☐ Serious disruption of family or social milieu which may be due to illness, death, divorce or separation of parent and child, severe conflict, torment and/or physical or sexual mistreatment.
- ☐ Severe disruption in life circumstances such as going to jail, losing housing, or living in an unfamiliar, unfriendly culture.
- ☐ Inability to meet needs for physical and/or material well being.
- ☐ Recent onset of severely disabling or life threatening illness.
- ☐ Difficulty avoiding exposure to active users and other pressures to partake in alcohol or drug use. *
- ☐ Episodes of victimization or direct threats of violence near current home.
- ☐ Overwhelming demands to meet immediate obligations are perceived.

☐ **EXTREMELY STRESSFUL ENVIRONMENT**

- ☐ An acutely traumatic level of stress or enduring and highly disturbing circumstances disrupting ability to cope with even minimal demands in social spheres such as:
  - ongoing injurious and abusive behaviors from family member(s) or significant other.
  - witnessing or being victim of extremely violent incidents brought about by human malice or natural disaster.
  - persecution by a dominant social group.
  - sudden or unexpected death of loved one.
- ☐ Unavoidable exposure to drug use and active encouragement to participate in use. *
- ☐ Incarceration or lack of adequate shelter.
- ☐ Severe pain and/or imminent threat of loss of life due to illness or injury.
- ☐ Sustained inability to meet basic needs for physical and material well being.
- ☐ Chaotic and constantly threatening environment.

* These criteria apply to persons with past or present difficulties with substance use.

***LEVEL OF SUPPORT:***

☐ **HIGHLY SUPPORTIVE ENVIRONMENT**

- ☐ Plentiful sources of support with ample time and interest to provide for both material and emotional needs in most circumstances.
- ☐ Effective involvement of Assertive Community Treatment Team (ACT) or other similarly highly supportive resources. *(Selection of this criterion pre-empts higher ratings)*

☐ **SUPPORTIVE ENVIRONMENT**

- ☐ Supportive resources are not abundant, but are capable of and willing to provide significant aid in times of need.
- ☐ Some elements of the support system are willing and able to participate in treatment if requested to do so and have capacity to effect needed changes.

☐ Professional supports are available and effectively engaged (i.e. ICM). *(Selection of this criterion pre-empts higher ratings)*

☐ **LIMITED SUPPORT IN ENVIRONMENT**

- ☐ A few supportive resources exist in current environment and may be capable of providing some help if needed.
- ☐ Usual sources of support may be somewhat ambivalent, alienated, difficult to access, or have a limited amount of resources they are willing or able to offer when needed.
- ☐ Persons who have potential to provide support have incomplete ability to participate in treatment and make necessary changes.
- ☐ Resources may be only partially utilized even when available.
- ☐ Limited constructive involvement with any professional sources of support that are available.

☐ **MINIMALLY SUPPORTIVE ENVIRONMENT**

- ☐ Very few actual or potential sources of support are available.
- ☐ Usual supportive resources display little motivation or willingness to offer assistance, or they are themselves troubled or hostile toward client.
- ☐ Existing supports are unable to provide sufficient resources to meet material or emotional needs.
- ☐ Client may be on bad terms with and unwilling to use supports available in a constructive manner.

☐ **NO SUPPORT IN THE ENVIRONMENT**

- ☐ No sources for assistance are available in environment either emotionally or materially.

**DIMENSION V. TREATMENT AND RECOVERY HISTORY**

This dimension of the assessment recognizes that a person's past experience provides some indication of how that person is likely to respond to similar circumstances in the future. While it is not possible to codify or predict how an individual person may respond to any given situation, this scale uses past trends in responsiveness to treatment exposure and past experience in managing recovery as its primary indicators. Although the recovery process is a complex concept, for the purposes of rating in this parameter, recovery is defined as a period of stability with good control of symptoms. While it is important to recognize that some clients will respond well to some treatment situations and poorly to others, and that this may in some cases be unrelated to level of intensity, but rather to the characteristics and attractiveness of the treatment provided, the usefulness of past experience as one predictor of future response to treatment must be taken into account in determining service needs. Most recent experiences in treatment and recovery should take precedence over more remote experiences in determining the proper rating.

☐ **FULLY RESPONSIVE TO TREATMENT AND RECOVERY MANAGEMENT**

- ☐ There has been no prior experience with treatment or recovery.
- ☐ Prior experience indicates that efforts in all treatments that have been attempted have been helpful in controlling the presenting problem.
- ☐ There has been successful management of extended recovery with few and limited periods of relapse even in unstructured environments or without frequent treatment.

☐ **SIGNIFICANT RESPONSE TO TREATMENT AND RECOVERY MANAGEMENT**

- ☐ Previous or current experience in treatment has been successful in controlling most symptoms but intensive or repeated exposures may have been required.
- ☐ Recovery has been managed for moderate periods of time with limited support or structure.

☐ **MODERATE RESPONSE TO TREATMENT AND RECOVERY MANAGEMENT**

- ☐ Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms.
- ☐ Previous treatment exposures have been marked by minimal effort or motivation and no significant success or recovery period was achieved.
- ☐ Unclear response to treatment and ability to maintain a significant recovery.
- ☐ At least partial recovery has been maintained for moderate periods of time, but only with strong professional or peer support or in structured settings.

☐ **POOR RESPONSE TO TREATMENT AND RECOVERY MANAGEMENT**

- ☐ Previous or current treatment has not achieved complete remission of symptoms or optimal control of symptoms even with intensive and/or repeated exposure.
- ☐ Attempts to maintain whatever gains that can be attained in intensive treatment have limited success, even for limited time periods or in structured settings.

☐ **NEGLIGIBLE RESPONSE TO TREATMENT**

- ☐ Past or current response to treatment has been quite minimal, even with intensive medically managed exposure in highly structured settings for extended periods of time.
- ☐ Symptoms are persistent and functional ability shows no significant improvement despite this treatment exposure.

**DIMENSION VI. ENGAGEMENT AND RECOVERY STATUS**

This dimension of the assessment considers a person's understanding of illness and treatment and ability or willingness to engage in the treatment and recovery process. Factors such as acceptance of illness, stage in the change process, ability to trust others and accept assistance, interaction with treatment opportunities, and ability to take responsibility for recovery should be considered in defining the measures for this dimension. These factors will likewise impact a person's ability to be successful at a given level of care.

☐ **OPTIMAL ENAGEMENT AND RECOVERY**

- ☐ Has complete understanding and acceptance of illness and its effect on function.
- ☐ Actively maintains changes made in the past (Maintenance Stage).
- ☐ Is enthusiastic about recovery, is trusting, and shows strong ability to utilize available resources and treatment.
- ☐ Understands recovery process and takes on a personal role and responsibility in a recovery plan.

☐ **POSITIVE ENAGEMENT AND RECOVERY**

- ☐ Has significant understanding and acceptance of illness and its effect on function.
- ☐ Willing to change and is actively working toward it (Action Stage).
- ☐ Positive attitude toward recovery and treatment, capable of developing trusting relationships, and uses available resources independently when necessary.
- ☐ Shows recognition of personal role in recovery and accepts significant responsibility for it.

☐ **LIMITED ENAGEMENT AND RECOVERY**

- ☐ Has some variability, hesitation or uncertainty in acceptance or understanding of illness and disability.
- ☐ Has limited desire or lacks confidence to change despite intentions to do so (Preparation Stage).
- ☐ Relates to treatment with some difficulty and establishes few, if any, trusting relationships.
- ☐ Does not use available resources independently or only in cases of extreme need.

(Adapted from the American Association of Community Psychiatrists LOCUS – Level of Care Utilization System for Psychiatric and Addiction Services Manual, Adult Version 2010)

- ☐ Has limited ability to accept responsibility for recovery.

☐ **MINIMAL ENAGEMENT AND RECOVERY**

- ☐ Rarely, if ever, is able to accept reality of illness or any disability that accompanies it, but may acknowledge some difficulties in living.
- ☐ Has no desire or is afraid to adjust behavior, but may recognize the need to do so (Contemplation Stage).
- ☐ Relates poorly to treatment and treatment providers and ability to trust is extremely narrow.
- ☐ Avoids contact with and use of treatment resources if left to own devices.
- ☐ Does not accept any responsibility for recovery or feels powerless to do so.

☐ **DISENGAGED AND STUCK**

- ☐ Has no awareness or understanding of illness and disability (Pre-contemplation Stage).
- ☐ Inability to understand recovery concept or contributions of personal behavior to disease process.
- ☐ Unable to actively engage in recovery or treatment and has no current capacity to relate to another or develop trust.
- ☐ Extremely avoidant, frightened, or guarded.

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